from the right radial artery, suddenly decreased from 96/62 mm Hg to 64/45 mm Hg. Blood pressure was decreasing gradually, and bolus injections of norepinephrine (0.5 or 1 mg) could not maintain a systolic blood pressure of greater than 50 mm Hg. Under the diagnosis of ruptured aneurysm, both a right femoral venous and a right femoral arterial cannula were inserted immediately, and partial cardiopulmonary bypass was started to maintain systolic blood pressure at 50 mm Hg after systemic heparinization (14,000 U). Thoracotomy was performed at the fifth intercostal space, and an aneurysmal rupture into the pericardial lumen was confirmed by findings of bloody pericardial effusion. The thoracic aorta proximal to the aneurysm was crossclamped at the level of Th 7, and thereafter systolic blood pressure at the right radial artery could be controlled between 70 and 90 mm Hg. A descending thoracic aneurysm repair (level between Th 7 and Th 9) was performed with a 20-mm graft (Gelweave, Sulzer Vascutek). The durations of aortic crossclamping and surgical intervention were 70 minutes and 6 hours, respectively. In the intensive care unit this patient awoke, was alert, and followed our commands but was unable to move his legs the day after the operation. Neurologic findings by a neurologist revealed spastic paraplegia, indicating ischemic spinal cord injury. Under sedation with propofol infusion (2-3 mg $\cdot$ kg^{-1} $\cdot$ h^{-1}), myogenic tc-MEP monitoring, however, demonstrated a reproducible waveform recorded from the left anterior tibial muscle in spite of his paraplegia (Figure). This paraplegia continued for 3 days after the operation, and his motor function recovered slightly, but neurologic findings one month after the operation revealed the continued presence of paraparesis.